CHILDREN FIRST
DUMFRIES PEDIATRICS

Well Child Check: 12 Month Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Can your child get himself to a standing position?	Yes	No	Unsure
Does your child take steps holding on to furniture?	Yes	No	Unsure
Does your child walk?	Yes	No	Unsure
Does your child pick up objects with the tips of the thumb and fingers?	Yes	No	Unsure
Does your child feed herself?	Yes	No	Unsure
Can you get your child to laugh?	Yes	No	Unsure
Does your child babble? (talk with made up words/sounds)	Yes	No	Unsure
Does your child say dada or mama, with specific meaning?	Yes	No	Unsure
Does your child use any gestures? (wave bye-bye, point)	Yes	No	Unsure
Does your child look at you when you call his or her name?	Yes	No	Unsure
Is your child completely weaned from the bottle?	Yes	No	Unsure
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	No	Yes	Unsure
Is your baby getting breast milk or formula?	Breast milk	Formula	Other
How much breast milk, formula or other milk does your child drink in 24 hours?_____ oz.			
Does your child eat meat (such as fish, chicken, beef, or pork)?	Yes	No	Unsure
Was your child born after the 37th week of pregnancy?	Yes	No	Unsure
Did your child weigh more than 5 pounds 8 ounces (2500 gm) at birth?	Yes	No	Unsure
Does your child sleep through the night?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/other measures when outdoors?	Yes	No	Unsure
Do you have the poison control number (800 222-1222) posted at home?	Yes	No	Unsure
Are there guns at your home, or any home your child regularly visits?	No	Yes	Unsure
Does your child have access to a pool that does not have a locked gate?	No	Yes	Unsure
Do you have any safety concerns in your home?	No	Yes	Unsure

If so, what are your concerns?

_____

Over the past 2 weeks, has mom ever felt down, depressed or hopeless?	No	Yes	Unsure
Over the past 2 weeks, has mom felt very little or no interest or pleasure in doing things?	No	Yes	Unsure
Who provides daytime care for your child? _____			
Does your water contain fluoride?	Yes	No	Unsure

CONTINUES ON OTHER SIDE

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Is your child on any medications or supplements, including vitamins? If so, please list below:

RISK ASSESSMENT FOR LEAD EXPOSURE:

Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds?	Yes	No	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint inside or outside the home?	Yes	No	Unsure
Does your child have a sibling or playmate who has or did have lead poisoning?	Yes	No	Unsure
Does your family use any of the following IMPORTED items: pottery for cooking or storing food, home remedies, dietary/herbal supplements, candy or eyeliner, (Kohl, Greta, Azarcon,Pay-loo-ah or others)? IF YES, please specify.	Yes	No	Unsure

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Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	Yes	No	Unsure
Since your child's last well check has a family member or contact had a positive tuberculosis test?	Yes	No	Unsure
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure

Do you have any international travel plans prior to your child's second birthday, if so, when and where?

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?

If so, please describe:

CONTINUES ON OTHER SIDE